CONFERENCE COMMITTEE REPORT
DIGEST FOR ESB 566

Citations Affected: IC 12-7-2-47.5; IC 12-15; IC 12-19-7.5-1; IC 12-24.

Synopsis: Health care services. Conference committee report to ESB 566. Requires an insurer to accept a Medicaid claim for services provided a Medicaid recipient for three years after the date the service was provided. Specifies the circumstances in which a Medicaid claim may not be denied by an insurer. States that notice requirements may be satisfied by electronic or mail submission (current law provides only for certified or registered mail). Requires an insurer to accept the state's right of recovery and assignment of certain rights as required by federal law. Adds certain less restrictive settings to the definition of children's psychiatric residential treatment services. Requires OMPP to conduct a study of Medicaid claims eligible for payment by a third party. Provides that if the study by OMPP reveals a percentage of at least 1%, OMPP shall implement an automated procedure for determining whether a Medicaid claim is eligible for payment by a third party before payment. Allows OMPP to implement a change in the office's maximum allowable cost schedule for prescription drugs 30 days after OMPP posts the changes on OMPP's Internet web site. (Current law requires 45 days before the change may be effective). Allows a pharmacy to determine not to participate in the Medicaid program as a result of a change in the schedule if the pharmacy notifies the office within 30 days of the change in the schedule taking effect. Changes the way charges are set at state mental health institutions. Repeals provisions concerning the per capita cost of treatment at state mental health institutions and the per capita cost of outpatient services. **(This conference committee report: (1) removes provision prohibiting OMPP from reducing provider reimbursement rates in appropriated money is reverted; (2) removes provisions concerning health care services provided to a person subject to lawful detention; (3) makes changes to the coordination of benefits study; (4) adds language from SB 318 concerning OMPP changes to the maximum allowable cost schedule for prescription drugs and pharmacy participation in the Medicaid program; and (5) adds language from SB 198 concerning charges at state mental health institutions.)**

Effective: Upon passage; July 1, 2007.

Adopted	Rejected

CONFERENCE COMMITTEE REPORT

MR. SPEAKER:

Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed House Amendments to Engrossed Senate Bill No. 566 respectfully reports that said two committees have conferred and agreed as follows to wit:

that the Senate recede from its dissent from all House amendments and that the Senate now concur in all House amendments to the bill and that the bill be further amended as follows:

Delete everything after the enacting clause and insert the following:

SECTION 1. IC 12-7-2-47.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 47.5. "Covered entity", for purposes of IC 12-15-23.5, has the meaning set forth in IC 12-15-23.5-1.**

SECTION 2. IC 12-15-13-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) **Except as provided by IC 12-15-35-50,** a notice or bulletin that is issued by:

(1) the office;

(2) a contractor of the office; or

(3) a managed care plan under the office;

concerning a change to the Medicaid program that does not require use of the rulemaking process under IC 4-22-2 may not become effective until forty-five (45) days after the date the notice or bulletin is mailed to the parties affected by the notice or bulletin.

(b) The office must mail a notice or bulletin described in subsection (a) within five (5) business days after the date on the notice or bulletin.

SECTION 3. IC 12-15-23.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 23.5. Coordination of Benefits Study

Sec. 1. As used in this chapter, "covered entity" has the meaning

set forth in 45 CFR 160.103.

Sec. 2. (a) Before January 1, 2008, the office shall:

(1) examine all Medicaid claims paid after January 1, 2001, and before July 1, 2007;

(2) determine which claims examined under subdivision (1) were eligible for payment by a third party other than Medicaid; and

(3) recover the claims that were determined under subdivision (2) to be eligible for payment by a third party other than Medicaid.

(b) The office shall require through an eligibility and benefit request, and a covered entity shall provide, any information necessary for the office to complete the examination required by this section. The office, after notice and hearing, may impose a fine not to exceed one thousand dollars ($1,000) for each refusal by a covered entity to provide information concerning an eligibility and benefit request for a Medicaid recipient requested by the office under this section.

Sec. 3. If at least one percent (1%) of the claims were determined under section 2 of this chapter to be eligible for payment by a third party other than Medicaid, the office shall develop and implement a procedure to improve the coordination of benefits between:

(1) the Medicaid program; and

(2) any other third party source of health care coverage provided to a recipient.

Sec. 4. If a procedure is developed and implemented under section 3 of this chapter, the procedure:

(1) must be automated; and

(2) must provide a system for determining whether a Medicaid claim is eligible for payment by another third party before the claim is paid under the Medicaid program.

SECTION 4. IC 12-15-29-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. (a) Subject to subsection (b), an insurer shall furnish records or information pertaining to the coverage of an individual for the individual's medical costs under an individual or a group policy or other obligation, or the medical benefits paid or claims made under a policy or an obligation, if the office does the following:

(1) Requests the information ~~in writing.~~ **electronically or by United States mail.**

(2) Certifies that the individual is:

(A) a Medicaid applicant or recipient; or

(B) a person who is legally responsible for the applicant or recipient.

(b) The office may request only the records or information necessary to determine whether insurance benefits have been or should have been claimed and paid with respect to items of medical care and services that were received by a particular individual and for which Medicaid coverage would otherwise be available.

SECTION 5. IC 12-15-29-4.5 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 4.5. (a) An insurer shall accept a Medicaid claim for a Medicaid recipient for three (3) years from the date the service was provided.**

(b) An insurer may not deny a Medicaid claim submitted by the office solely on the basis of:

(1) the date of submission of the claim;

(2) the type or format of the claim form;

(3) the method of submission of the claim; or

(4) a failure to provide proper documentation at the point of sale that is the basis of the claim;

if the claim is submitted by the office within three (3) years from the date the service was provided as required in subsection (a) and the office commences action to enforce the office's rights regarding the claim within six (6) years of the office's submission of the claim.

(c) An insurer may not deny a Medicaid claim submitted by the office solely due to a lack of prior authorization. An insurer shall conduct the prior authorization on a retrospective basis for claims where prior authorization is necessary and adjudicate any claim authorized in this manner as if the claim received prior authorization.

SECTION 6. IC 12-15-29-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 7. (a) The notice requirements of section 4 of this chapter are satisfied if:

(1) the insurer receives from the office, ~~by certified~~ **electronically** or ~~registered~~ **by United States** mail, a statement of the claims paid or medical services rendered by the office, together with a claim for reimbursement; or

(2) the insurer receives a claim from a beneficiary stating that the beneficiary has applied for or has received Medicaid from the office in connection with the same claim.

(b) An insurer that receives a claim under subsection (a)(2) shall notify the office of the insurer's obligation on the claim and shall:

(1) pay the obligation to the provider of service; or

(2) if the office has provided Medicaid, pay the office.

SECTION 7. IC 12-15-29-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) IC 27-8-23 applies to this section.

(b) To the extent that payment for covered medical expenses has been made under the state Medicaid program for health care items or services furnished to a person, in a case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the person to payment by any other party for the health care items or services.

(c) As required under 42 U.S.C. 1396a(a)(25), an insurer shall accept the state's right of recovery and the assignment to the state of any right of the individual or entity to payment for a health care item or service for which payment has been made under the state Medicaid plan.

SECTION 8. IC 12-15-35-50 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2007]: **Sec. 50. (a) IC 12-15-13-6 does not apply to this section.**

(b) The office shall maintain an Internet web site and post on the web site any changes concerning the office's maximum allowable cost schedule for drugs.

(c) A change in the office's maximum allowable cost schedule for drugs may not take effect less than thirty (30) days after the change is posted on the office's Internet web site.

(d) The office is not required to mail a notice to providers concerning a change in the office's maximum allowable cost schedule for drugs.

(e) A pharmacy may determine not to participate in the Medicaid program because of a change to the office's maximum allowable cost schedule for drugs if the pharmacy notifies the office not less than thirty (30) days after the changes take effect.

SECTION 9. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "children's psychiatric residential treatment services" means services that are:

(1) eligible for federal financial participation under the state Medicaid plan; and

(2) provided to individuals less than twenty-one (21) years of age who are:

(A) eligible for services under the state Medicaid plan;

(B) approved by the office **as eligible** for admission to and treatment in a private psychiatric residential treatment facility; and

(C) **either** residing in a:

(i) private psychiatric residential facility for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations; **or**

(ii) less restrictive setting and participating in a federally approved community alternatives to psychiatric residential treatment facilities demonstration grant that provides safe, intensive, and appropriate services under an approved treatment plan that complies with federal and state Medicaid law.

SECTION 10. IC 12-24-13-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) Each ~~patient in a~~ state institution ~~and the responsible parties of the patient, individually or collectively,~~ shall ~~pay for the ensuing fiscal year an amount not to exceed the per capita cost at that state institution.~~ **establish a charge structure for institutional services and treatment. The charge structure must be approved by the director of the division before July 1 of each year and, once approved, the charge structure must be effective for the following state fiscal year.**

(b) Except as provided in section 5 of this chapter, each patient in a state institution and the responsible parties, individually or collectively, are liable for the payment of the ~~cost of~~ **charges for the**

treatment and maintenance of the patient.

SECTION 11. IC 12-24-13-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. If a patient in a state institution has insurance coverage that covers hospitalization or medical services in psychiatric hospitals, all benefits under the insurance coverage ~~in an amount not to exceed the cost of treatment and maintenance of the patient,~~ shall be assigned to the appropriate division.

SECTION 12. IC 12-24-13-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. The appropriate division shall issue to any party liable under this chapter for any type of psychiatric service statements of sums due as maintenance charges. The division shall require the liable party to pay monthly, quarterly, or otherwise as may be arranged an amount not exceeding the maximum ~~cost~~ **charge** as determined under this chapter.

SECTION 13. IC 12-24-13-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 11. The estate of a patient who receives care, treatment, maintenance, or any other service furnished by the division at the state's expense is liable for payment ~~of the cost~~ of **the charges as determined under this chapter for** the service. The estate is exempt from the requirements of section 10 of this chapter or any part of this chapter directly in conflict with the intent of the chapter to hold a patient's estate liable for payment.

SECTION 14. IC 12-24-14-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. The billing and collection of maintenance ~~expenses~~ **charges** under this article shall be made by the division or a unit of the division designated by the director.

SECTION 15. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: IC 12-24-13-3; IC 12-24-13-8; IC 12-24-13-9.

SECTION 16. **An emergency is declared for this act.**

(Reference is to ESB 566 as reprinted April 10, 2007.)

Conference Committee Report
on
Engrossed Senate Bill 566

Signed by:

Senator Dillon Chairperson	Representative Brown C
Senator Mrvan	Representative Brown T
Senate Conferees	**House Conferees**